IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANGELO DiLORENZO, Plaintiff, v. UFCW LOCAL 56, HEALTH & WELFARE FUND, Defendant.	HON. JEROME B. SIMANDLE Civil No. 05-4671 (JBS) **MEMORANDUM OPINION AND ORDER**

SIMANDLE, U.S. District Judge:

This matter is before the Court upon the unopposed motion to dismiss by Defendant UFCW Local 56, Health & Welfare Fund ("Fund") under Rule 12(b)(6), Fed. R. Civ. P., seeking dismissal of the Complaint in its entirety.[1] Because Plaintiff's state law claims are totally pre-empted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132, and any ERISA claims that Plaintiff may have are barred as a matter of law for failure to exhaust remedies under the UFCW Local 56 Health and Welfare Fund Benefits Booklet and Plan Document ("Plan"), the

[1] In deciding a Rule 12(b)(6) motion to dismiss, a court should look to the face of the complaint and decide whether, taking all of the allegations of fact as true and construing them in a light most favorable to the non-movant, plaintiff's allegations state a legal claim. Scheuer v. Rhodes, 416 U.S. 232, 236 (1974); Markowitz v. Northeast Land Co., 906 F.2d 100, 103 (3d Cir. 1990). Only the allegations in the complaint, matters of public record, orders, and exhibits attached to the complaint matter, are taken into consideration. Chester County Intermediate Unit v. Pennsylvania Blue Shield, 896 F.2d 808, 812 (3d Cir. 1990).

motion will be granted and the Complaint will be dismissed. The Court finds as follows:

1. The Plan, administered by the Fund, is a multi-employer health and welfare plan within the meaning of 29 U.S.C. § 1002(1), (3) and (37). The Plan provides, among other things, group health benefits to Plan participants and beneficiaries pursuant to its terms and conditions. Plaintiff is a participant of the Plan.

2. As required by ERISA, the Plan contains a "Statement of ERISA Rights," and a mandatory claims procedure for review of denied claims. Specifically, where a "post-service claim" involving health benefits is denied, the Plan requires a claimant to file a written request for review with the Appeals Administrator within 180 days after the claimant has received notice of the denial.[2] (Def. Ex. 1, Plan at 81.) Once a request for review of a "post service claim" is filed, the Fund will review the denial and render its decision within 60 days after receipt of the appeal. (Id.)

[2] Under the Plan, a "post service claim" is "a claim for a particular benefit or for a particular service after the benefit or service has been provided." (Def. Br. at 2 n.3.)

3. On or about April 25, 2004, Plaintiff's son received medical services from Delaware Valley Plastic Surgery ("Provider"). Following Plaintiff's eventual submission of the appropriate information, the Fund determined that Plaintiff received services from an out-of-network provider and that the Provider's charge exceeded the Fund's reasonable and customary allowance for the service performed.

4. The June 27, 2005 Benefit Statement and Check Receipt ("Receipt") shows that the Fund had covered the appropriate portion of the Plaintiff's claims for benefits, and that a check for services performed was tendered directly to the Provider. (Def. Ex. 2.) The Receipt indicates that Plaintiff retained a balance of $1,453.46 in charges not covered by the Plan.[3] (Id.)

5. On August 19, 2005, Plaintiff filed a notice of appeal with the Fund. As of the filing of the instant motion on September 29, 2005, the Fund had not issued a decision on Plaintiff's appeal.

[3] The Plan cautions its participants that "While it is not mandatory that you be treated by a Physician participating in the Preferred Provider Organization (PPO) . . . this PPO arrangement does provide you with the opportunity to save on your medical expenses. Remember, you may still be treated by any Physician of your choice, but this benefit only applies when you are treated by one of the PPO Physicians." (Def. Ex. 1, Plan at 42.)

6. This Complaint was filed by Plaintiff Pro Se in Superior Court of New Jersey, Special Civil Part, Camden County, Small Claims Section, on August 22, 2005. Defendant removed the action here on September 22, 2005.

7. Plaintiff's state law claim must be dismissed first, because ERISA provides the exclusive remedy for participants or beneficiaries to recover benefits under an employee benefit plan such as the Plan here. Pilot Life Ins. v. Dedeaux, 481 U.S. 41, 43 (1987) (holding claims relating to employee benefit plan preempted by ERISA).

8. Second, Plaintiff failed to exhaust internal Plan remedies. With limited exceptions not applicable here, "a federal court will not entertain an ERISA claim unless the plaintiff has exhausted the remedies available under the plan." Weldon v. Kraft, Inc., 896 F.2d 793, 800 (3d Cir. 1990) (citing Wolf v. Nat'l Shopmen Pension Fund, 728 F.2d 182, 185 (3d Cir. 1984)).

9. For the foregoing reasons, the Court will grant the motion to dismiss by Defendant and dismiss the Complaint without prejudice so as to allow Plaintiff to exhaust Plan remedies. See D'Amico v. CBS Corp., 297

F.3d 287, 293 n.9 (3d Cir. 2002) (noting district courts maintain discretion to dismiss ERISA claim without prejudice to allow plaintiffs to exhaust plan remedies). Therefore,

IT IS this **7th** day of November 2005 hereby

ORDERED that the unopposed motion to dismiss by Defendant UFCW Local 56, Health & Welfare Fund under Rule 12(b)(6), Fed. R. Civ. P., [Docket Item 3] shall be, and hereby is, **GRANTED**; and

IT IS FURTHER ORDERED that the Complaint shall be, and hereby is, **DISMISSED WITHOUT PREJUDICE**.

s/ Jerome B. Simandle
JEROME B. SIMANDLE
U.S. District Judge